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We Want Your Opinion

Letters to the Editor are welcome. Let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Bureau of Medicine and Surgery, Bldg 1, Rm 1217, 2300 E Street, NW, Washington, DC, 20372-5300 or Janice.Hores@med.navy.mil or 19native47@verizon.net

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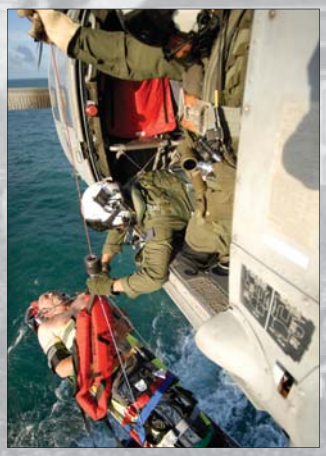

COVER: Atlantic Ocean. AW2 Zachary Gillespie and AW3 Phillip Gonzales, Helicopter Sea Combat Squadron, Detachment 5, USS *Kearsarge* (LHD-3), hoist a Norwegian man from the ocean-going tug SVC *Tanux* II in response to an emergency medical distress call. Photo by MC2 Erik Barker, USN

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Articles and Book Review Submissions

Navy Medicine considers for publication photo essays, artwork, and manuscripts on research, history, unusual experiences, opinions, editorials, and professional matters. Contributions are suitable for consideration by *Navy Medicine* if they represent original material, have cleared internal security review, and received chain of command approval. An author need not be a member of the Navy to submit articles for consideration. For guidelines on submission, please contact: Janice Marie Hores, Janice.Hores@med.navy.mil or 19native47@verizon.net

Navy Medicine is also looking for book reviews. If you've read a good book dealing with military (Navy) medicine and would like to write a review, the guidelines are:

- Book reviews should be 600 words or less.
- Introductory paragraph must contain: Title, author, publisher, publisher address. Year published. Number of pages.
- Reviewer ID: sample:

CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.

SAVE A TREE

If you would like to receive your issue electronically via email in PDF format, please contact Janice Marie Hores, Editor, at Janice.Hores@med.navy.mil or 19native47@verizon.net

NAVY MEDICINE IS COMMITTED TO ALL WE ARE HONORED TO SERVE

In mid-November, ADM Gary Roughead, Chief of Naval Operations, released the Navy Ethos, a set of Navy fundamental principles and values to emphasize the importance of one Navy team, active duty, Reserve, and civilian. "We are the United States Navy, our nation's sea power, ready guardians of peace, victorious in war. We are professional sailors and civilians, a diverse and agile force exemplifying the highest standards of service to our nation, at home and abroad, at sea and ashore. Integrity is the foundation of our conduct; respect for others is fundamental to our character, decisive leadership is crucial to our success. We are a team, disciplined and well prepared, committed to mission accomplishment. We do not waver in our dedication and accountability to our shipmates and families. We are patriots, forged by the Navy's core values of honor, courage, and commitment. In times of war and peace, our actions reflect our proud heritage and tradition. We defend our nation and prevail in the face of adversity with strength, determination, and dignity. We are the United States Navy."

Navy medicine, being a core asset of the Navy and its Maritime Strategy, exemplifies this one Navy concept by means of Force Health Protection. The Navy Ethos is a pledge for Navy medicine to uphold the principles of the Sailor's Creed. We are built on a solid foundation of proud traditions and a remarkable legacy. Navy medicine does one thing every day and we do it very well, Force Health Protection. We prepare our forces to deploy. We deploy ourselves to prevent, and if necessary, treat disease and injury.

We tend to our injured on the battlefield, and restore our warrior's health when they return to our military treatment facilities. Our active duty, Reserve, and civilian workforce are committed and passionate, and ready to get the job done—anytime, anywhere.

At the same time, these healthcare providers participate in humanitarian assistance and disaster relief efforts and other operations where medical care is needed for sustainment and success.

One such example of this positive global impact is Continuing Promise 2008. The amphibious assault ship USS *Kearsarge* (LHD-3) was the primary platform for the Caribbean phase of this humanitarian/civic assistance mission. Medical staff embarked onboard *Kearsarge* provided dental and medical care throughout the Caribbean region.

We are a critical component of the joint medical force with other services, the interagency community, allies, international partners, as well as medical and non-governmental organizations, and corporations.

In Africa, HN Knasi Kusi separated doxycycline hyclate malaria medication into weekly doses in the pharmacy at Seth Michaud emergency medical facility at Camp Lemonier Djibouti. The Camp Lemonier medical facility cares for almost 2,500 Army, Navy, Air Force, Marine Corps, and Department of Defense (DOD) personnel supporting joint military missions in Africa.

On the home front, Lead Mammography Technologist Carmen Waters at the Breast Health Center at the Naval Medical Center San Diego assisted a patient, who was waiting for prescriptions, prepare for a mammography. In conjunction with the pharmacy, the Breast Health Center started a new program called "Mammograms While You Wait" that allows patients to take the exam while their prescriptions are being filled. Providing these services have saved patients time and demonstrate the efficiency of our military treatment facilities and staff.

Navy medicine will continue to maintain the right medical capabilities across the full range of military operations through the appropriate mix of accession, retention, education, and training incentives.

The extent to which we dedicate our energies and endeavors to patient and family centered care will continue to define our value, not only to them but also to our nation and the citizens they protect. Navy medicine will continue to be a foremost leader in healthcare, both preventive and restorative, and a powerful component in the scientific evolution of medicine and research.

But what sets us apart from similar institutions in this nation and the world is the additional nobility of essential commitment to care for our nation's warriors. We care for those who defend and have defended our homeland, and the essential freedoms that we all enjoy as American citizens. And in caring for our nation's warriors—past, present, and future—we also care for their families. They too serve their country through the daily sacrifices they make and their many individual contributions to support not only their own sailor or Marine, but also the larger community around them.

Our cutting edge technology and state-of-the-art equipment, coupled with the best-trained medical providers in the world, will ensure our continued success. And yet, these resources and technologies should never be their own ends, but should serve to facilitate our continued execution of our basic mission.

Regardless of the challenges we may face, our values, both individual and collective, will always lead us in the right direction.

Navy medicine has a corporate culture second to none. Our beliefs and relationships between each other and the services we provide will guide our decisions and our actions, because we can never go wrong if we truly make the patients and families the center of our enterprise.

When individuals possessing and sharing the same high values stand together for a common purpose, they create a very powerful force that drives positive behavior and actions learned within the group are then transferred between people over time. As members of Navy medicine we are uniquely blessed in sharing a most noble value.

Navy medicine's 167-year history of excellence, pride, and determination has created the atmosphere that ensures our success. Since the establishment of the Bureau of Medicine and Surgery, Navy medicine has changed and evolved, and will continue to do so.

Regardless of the varying paths on which history has taken us, we have always maintained our calling to promote the health and well being of our sailors and Marines and their families. This essential value and deeply held principle is what sets us apart from even the most altruistic of our civilian counterparts.

One definition of value includes "to rate in usefulness, importance, and general worth." Our patients rate our usefulness and define our importance and general worth. Therefore, we put them and their families at the center of everything we do. They are the reason we exist. The day we discontinue to do that, the day we forget why we are here, is the day that Navy medicine should cease to exist.

Additionally, we have created a critical mass of esprit-de-corps that few organizations can truly experience or emulate.

So, as we continue to enjoy the success of our enterprise created by our corporate culture and our value system, I ask you to look out for each other and take care of your shipmates. I would also like to thank each and every member of the Navy medicine team for all that you contribute to our noteworthy success. Whether on the home front, abroad, or in a deployed status, you are Force Health Protection in action and you are an integral component of our finely tuned machine. I appreciate all you do and I value each and every one of you—it is my honor to serve our great country with you.

VADM Adam Robinson, Jr.

Letter to the Editor

As a sailor and Hospital Corpsman, I have enjoyed reading *Navy Medicine* magazine over the last three decades. As a history buff, I especially enjoy the articles concerning the history and traditions relative to Navy medicine, particularly the Hospital Corps. I would like to extend a heartfelt thank you to the staff of *Navy Medicine* magazine for the good work that they do in publishing a top quality periodical.

In view of his Farewell editorial published in the November-December 2008 edition of *Navy Medicine* magazine, I would specifically like to thank Jan Herman for the 30 plus years he has dedicated to the Navy medicine team, and for not only keeping us current on the latest technologies in the field of medicine, keeping us up-to-date on BUMED's most recent current events, but mostly for his efforts in keeping us steeped in the honor, tradition, and history that makes Navy medicine the special organization that it is.

From June of 1998 to September of 2002, I had the distinct honor and privilege of serving as the Course Director of the Health Resources Management (HRM) program at what was then, Naval School of Health Sciences (NSHS) and subsequently Naval Medical Education and Training Command (NMETC). Once every 6 weeks, we imported 40 Chief, Senior Chief, and Master Chief Petty Officers into Washington, DC, for a 2-week course designed to provide them technical and professional information and enhanced leadership skills that would allow them to perform at a higher level when returning to the fleet. One of the highlights of the HRM program was our day-long trip to BUMED where the attendees would get to meet their counterparts assigned to BUMED, spend time with the Force Master Chief and Surgeon General, if available, and to gain a better understanding of the functions of BUMED. The day-long visit would wrap up with Jan Herman's delightful tour of the BUMED facility and an oration of the building's history. The attendees would always marvel at Jan's in-depth knowledge and his unique ability to memorize, literally, volumes of valuable and historical information relative to the past, present, and future of Navy medicine. At the time, we all pretty much knew how busy Jan was, but he never missed a date, was never a moment late and his indelible mark on Navy medicine's Chief Petty Officers will last a lifetime for many!

To that end, I would like to personally thank Mr. Jan Herman for all that he has done in the preservation of Navy medicine's history and for all that he did for the HRM program when I was dropping 40 Chief Petty Officers on his doorstep for the "grand tour!"

Best wishes for many more years of continued success as a Special Assistant to the Surgeon General.

HMCM(SW/FMF) Brian D. Pampuro, USN(Ret.),
Hospital Corps, 1976-2006.

VA OPENING 31 NEW OUTPATIENT CLINICS

Veterans will have easier access to world-class healthcare under a Department of Veterans Affairs (VA) plan to open 31 new outpatient clinics in 16 states.

Secretary of Veterans Affairs Dr. James B. Peake announced VA will establish new clinics in Alabama, Arkansas, California, Florida, Georgia, Hawaii, Illinois, Iowa, Maryland, Michigan, Minnesota, Mississippi, Missouri, North Carolina, Pennsylvania, and Vermont.

"VA is committed to providing world-class healthcare to the men and women who have served this nation," Peake said. "These new clinics will bring VA's top-notch care closer to the veterans who have earned it."

With 153 hospitals and about 745 community-based clinics, VA operates the largest integrated healthcare system in the country. VA's medical care budget of more than $41 billion this year will provide healthcare to about 5.8 million people during nearly 600,000 hospitalizations and more than 62 million outpatient visits.

"Community-based medicine is better medicine," said Dr. Michael Kussman, VA's Under Secretary for Health. "It makes preventive care easier for patients, helps healthcare professionals have closer relationships with their patients, and permits easier follow-ups for patients with chronic health problems."

The community-based outpatient clinics, or CBOCs, will become operational by late 2010, with some opening in 2009. Local VA officials will keep communities and their veterans informed of milestones in the creation of the new CBOCs.

VA's Proposed Sites for New Outpatient Clinics:

- Alabama—Monroe County (2010)
- Arkansas—Faulkner County (2010), Pope County (2010)
- California—Lake County (2010), Oakhurst (2010), Susanville (2010), Yuba County (2010)
- Florida—Brandon (2010), Clermont (2010)
- Georgia—Blairsville (2010)
- Hawaii—Leeward (Honolulu, 2010)
- Illinois—Carbondale (2009), Harrisburg (2010), Sterling (2010)
- Iowa—Decorah (2010)
- Maryland—Fort Meade (2010), Montgomery County (2010)
- Michigan—Bad Axe (2010), Cadillac (2010), Cheboygan (2010), Grayling (2010)
- Minnesota—Southern central border (2010), Southwest metro area (exact locations to be determined, 2010)
- Mississippi—Pike County (2010)
- Missouri—Excelsior Springs (2009), Sikeston (2009), Sedalia (2010)
- North Carolina—Edenton-Elizabeth City (2010), Goldsboro (2010)
- Pennsylvania—Cranberry Township (2009)
- Vermont—Brattleboro (2010)

–VA Press Release.

CCPD USES LSS PROCESSES TO STREAMLINE CREDENTIALING FOR DIRECT COMMISSIONED OFFICER HEALTHCARE PROVIDERS

NMSC's Centralized Credentials and Privileging Department (CCPD) assumed the responsibility for initial credentials verification for prospective Direct Commissioned Officer (DCO) Navy healthcare providers.

CCPD had previously credentialed and privileged only Navy Reserve healthcare providers and clinical support staff.

CCPD now works directly with Commander, Navy Recruiting Command (CNRC), and Navy recruiters "to ensure that only fully qualified healthcare providers are accessed into the Navy through a direct commission," said Mrs. Becky Boyrie, CCPD Department Head. "Previously, Navy medical staff service professionals (MSSPs) weren't involved in the initial stages of gaining healthcare providers into the Navy."

CCPD and CNRC used Lean Six Sigma methodologies to ensure the entire DCO process was mapped out and any potential bottlenecks removed prior to moving forward with the contract, said Mr. Scott Olivolo, CCPD Director and a Lean Six Sigma Green Belt.

"Using Lean Six Sigma tools such as process flow diagrams enabled us to clearly illustrate, in a logic sequence, the multiple, oftentimes non-linear steps in the DCO process," said Olivolo. "This also showed us who is responsible for a particular action or decision along the way."

The flow diagram also helped the Navy recruiters visualize what happens before, during, and after the DCO is accessed into the Navy, and how CCPD will improve the end product, a completed credentials file to the customer.

The Armed Forces Institute of Pathology (AFIP) previously held the contract for credentialing prospective DCO providers. Once recruiters identified a prospective candidate, AFIP would build a portfolio comprised of all verified qualifications (the credentialing process). AFIP would then report their findings to the Navy medicine career plans officer to determine a candidate's eligibility. Unfortunately, once the DCO provider was fully accessed into the Navy, the credentialing information would not be forwarded to the gaining Navy healthcare facility. And the credentials then needed to be re-verified.

"Now we're going to have a provider's credentialing information well before those providers are assessed and commissioned into the Navy," said Boyrie. "We now send the established credentials file directly to where that provider will be working in the Navy. Then it's a matter of a provider completing the application for privileges, which might take only a couple of weeks to process."

Though the initiative is in the early stages, Boyrie believes the new LSS-based process is going well, primarily due to the CCPD staff of well qualified MSSPs with many years of credentialing and privileging experience.

"That's important because when a patient is in that exam room, they should feel confident and comfortable in knowing their provider is fully qualified," said Boyrie. "As MSSPs our job is to not assume, but rather to verify with absolute certainty that each provider is fully qualified to be involved in patient-care activities."

CCPD manages both the credentials and privileges for many different healthcare specialties, including physicians, dentists, nurse practitioners, and many other allied health professionals.

In regards to the new accession credentialing initiative, the initial feedback from CNRC, BUMED, and the career plans officers has been very positive.

"At the end of the day, we aim to deliver a completed credentials file to the gaining command, which they will use to fully privilege a provider," said Boyrie. "The value of this service cannot be understated in terms of Navy medicine's ability to put outstanding practitioners to work in a timely manner to take care of our patients worldwide."

–Story by MC1(SW) Arthur N. De La Cruz, Naval Medicine Support Command Public Affairs, Jacksonville, FL.

ANTHRAX VACCINE MESSAGE CHANGE ROUTE OF ADMINISTRATION AND CHANGE IN DOSING SCHEDULE

The food and drug administration (FDA) has approved a change in the route of administration for the anthrax vaccine adsorbed (AVA) from a subcutaneous (SC) injection to an intramuscular (IM) injection.

Following the manufacturer's new package insert, Navy medical personnel shall administer the AVA via the intramuscular route. The initial AVA series shall be administered as follows: 0.5 Ml doses at 0, 4 weeks, 6 months, 12 months, and 18 months. The 2-week dose is no longer required.

For members receiving orders to locations covered by the mandatory anthrax program and who are subject to the mandatory anthrax program for the first time, the goal is to ensure that the member has received the first two doses of the five-dose series prior to arrival in theater.

Personnel resuming anthrax immunizations will continue the dosing schedule where they left off (i.e. next dose in the series). Per the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), the primary series does not need to be restarted regardless of the time elapsed since the last dose. Once the primary series of five doses is completed it is never repeated.

Personnel who are required to continue the anthrax vaccine immunization program (AVIP) and who have completed the primary series are only required to receive an annual booster to maintain full immunity.

All other DOD, Navy, and Marine Corps policies pertaining to the ACIP remain in effect. Medical department personnel shall continue to follow current policy for administering the anthrax vaccine.

The FDA letter, new package insert, and MILVAX agency memorandum are available at: www.anthrax.mil/avip2008

Other useful information such as the AVIP education tool kit can be found and downloaded at the milvax website: www.anthrax.mil

Medical department personnel responsible for administering the AVIP should monitor this website for the latest information regarding the anthrax vaccine.

The anthrax vaccine immunization program remains a commander's force protection responsibility. Medical department personnel shall assist their commanders in complying with this responsibility by ensuring they properly identify, screen, and educate personnel prior to vaccination; properly administer and document vaccine administration; and ensure appropriate medical evaluations for all vaccine-related adverse events.

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U.S. Fleet Forces Command Establishes IA Common Operation

U.S. Fleet Forces Command (USFF), the Executive Agent for the Individual Augmentee (IA) Continuum, has released IA GRAM 08-2 as part of its ongoing goal to inform IA sailors and family members on issues relating to deployment, readiness, and policies in the support of the war on terrorism.

IA GRAM 08-2 announces the establishment of the IA Common Operating Picture (IA COP). The IA GRAM outlines procedures for sailors and family members to utilize the Navy Family Accountability and Assessment System (NFAAS), which will be an essential enabling tool for maintaining the IA COP. NFAAS provides sailors, families, and commands with a "one stop shop" comprehensive online service used to enter, update, maintain, and review personal and family contact information.

NFAAS is also used to account for Navy families in times of crisis, like recent and upcoming hurricanes.

The IA COP provides command leadership with tools to effectively support IA sailors and families.

A new requirement through the IA COP will be for commands that have current IA's, to designate a Command IA Coordinator (CIAC). The CIAC will use NFAAS to maintain current family information through the system, where the IA COP is maintained. "CIACs can also track pre-deployment requirements for IA sailors and families," said CDR Jim Lindsey, USFF NFAAS coordinator. "Some of these requirements include if a member has received orders, received an IA Handbook, and the periodicity of how often families wish to be contacted from either FFSC (Fleet and Family Support Center) or the parent command."

NFAAS can be accessed by secured login at: https://navyfamily.navy.mil. IA sailors and families are encouraged to review and update their personal information Further information for IA sailors and families can be found at: www.cffc.navy.mil/augmentees/index.htm.

–U.S. Fleet Forces Public Affairs.

Campa Credits Education, Deckplate Leadership with Success, Urges Leaders to Take Care of Sailors

The Master Chief Petty Officer of the Navy (MCPON) has emphasized the importance of good leadership and education during his tenure as the Navy's senior enlisted sailor.

While reflecting on the multiple accomplishments of the past 2 years, strengthening deckplate to leadership, retention, and diversity in the Navy, MCPON Joe R. Campa, Jr., humbly summed up his legacy. "If there is anything I want to be remembered for, it is being remembered as a good Chief." Campa said. "That is one of the highest compliments a Chief can attain."

Campa uses his own Navy career as an example of how education can open the path to success. He wasn't always sure he wanted to join the Navy, but he knew he would be in the military.

"My father served in the Army during the Korean War, and my uncle was a Marine during Vietnam. I think the seed was planted with those two pushing me towards military service," said Campa. "I thought about both of those branches of service until I met a Navy recruiter."

The recruiter changed Campa's perspective and his life. "The Navy recruiter had such a passion for going to sea and for serving our nation that it made me want to be part of this organization," Campa said. "I don't remember the programs he talked about, but I remember the stories he told about being on board a ship, the places that he had visited, and how much he missed being in the fleet. The way he spoke about those things told me that this organization was something special."

Campa, like many sailors at the time, came into the Navy having never finished high school. "I don't think at first that it had that much impact on me," Campa said. "I didn't start out as a hospital corpsman, I started out as a deck seaman. The first 6 or 7 months I was in, I was learning as much as I could about the Navy and the ship. But I knew in the back of my mind that if I wanted to do more, I would have to take that step and finish my degree."

Campa then went on to get his GED and started taking college courses. "Throughout my career when the opportunity presented itself, I would take a class," Campa said. "At first it was just to improve my leadership skills—writing classes, public speaking—those abilities that would complement my ability as a leader and as a corpsman. I came to a point where I had taken several of these classes, and I thought of shaping them into a degree."

Campa received his bachelor of science degree from Excelsior years later while attending the U.S. Army Sergeants Major Academy. All services send senior enlisted to one another's leadership schools. He took his willingness to learn further, going to the Naval War College. He graduated with a master of science in strategic studies. "It is a very challenging program," Campa said of the year-long in-residence course of study.

The MCPON's first mentor is tied closely with his vision of what a leader should exemplify, deckplate leadership. "My first chief had a big impact on me. I still look at what he did," Campa said. "When he spoke, he spoke with such credibility because he had such a strong knowledge of his ship, his rate, and the people that he led; that inspired me to want to do well for him. He planted some seeds, but I have been fortunate throughout my career to have good, strong, deckplate leaders, those who kept their focus on their people and measured their success through them. That is what I tried to bring back with deckplate leadership. That kind of leadership is traditional of the chiefs' mess and critical to our people and our Navy."

He added that he does not get excited when meeting someone, famous or not, but there was one exception to the rule. "I was getting ready to go to my first command master chief tour, and I was stationed in Great Lakes. The region master chief, Chief of Naval Operations-directed Master Chief (CNOCM) Duffy Merril, invited my wife and me to have dinner at his home. When we got there, he had a surprise for us; the first MCPON, Delbert D. Black, and his wife, Ima, were both there. I had read stories about him throughout my career. To listen to him talk about our Navy and the events that helped shape it was inspiring. I realized that what he was telling me was not just about things he saw, he was passing down a little bit of our Navy's history from one generation of chiefs to the next. He walked me out to my car, shook my hand, and told me not to forget who raised me in the Navy and who I worked for," he said. "It was one of the most memorable evenings of my career."

Campa, in his offices at the Navy Annex in Arlington, VA. Campa left office 13 December and will retire 1 April. Photo by Sheila Vemmer, *Navy Times*

Campa feels every sailor should have a sense of the history of the Navy. "Every sailor should know where he comes from," Campa said. "They need to have a grasp of the organization they belong to. I don't believe any leader can be effective if you don't understand who you are, what you do, and where that came from." And while he agrees that chiefs should be knowledgeable, the MCPON doesn't think that degrees are the answer to whether a chief is suitable to be promoted. The new chief's evaluation still measures professional growth and education, Campa explained. The measurement is not just college education, but different kinds of education, and training which makes the determination fair. The new evaluation is something Campa thinks was long overdue.

"We developed the chief petty officer mission, vision, and guiding principles shortly after I became MCPON. It goes to the heart of the services a chief should always provide, no matter what job title. Guiding principles serve as the foundation to who the chiefs are. 'You never stop being the chief.' I felt there was a better way to align what we are evaluating our CPOs on and what is expected of them as chiefs." Campa believes being the first Hispanic master chief petty officer of the Navy is a classic example of the Navy's diversity. "No matter what your background, what you look like, what the color of your skin is, the opportunities that you have in the Navy and how far you can go in this organization are based on your abilities," Campa said. "I don't think there is a person in the Navy today that feels that they have to sacrifice their culture or heritage to be part of this organization," Campa continued. "Being a Hispanic MCPON, or even being a Hispanic chief or first class petty officer, there are some folks that are going to share your heritage. Whether you realize it or not, those that share your heritage will look to you as a role model."

"With that comes the responsibility to give back to that community. You do that by sharing the understanding of their culture." Throughout his 27 years of service the MCPON has seen many changes. The largest change he thinks is the Homeport Ashore Program. "It's probably the biggest quality of life initiative since I have been in the Navy," Campa said. "We are taking those sailors off the ship and giving them a room in the barracks when they are not out at sea. It is a huge cultural shift. There were a lot of folks in the Navy that didn't believe we should do this. They felt if living on ship was good enough for them, it should be good enough for new sailors. But it was the right thing to do; it was critical."

While Campa sees improving the quality of life will help retention, he believes that the best retention tools are inside of each naval leader. "Give your sailors a sense of accomplishment," Campa said. "We see it happening all over the fleet. Good leadership sets their sailors up for success and takes a genuine interest in the growth and development of their sailors. There isn't anything that a well led sailor will not do for our Navy and our country."

–Story by MC1 Tim Comerford, Commander, Navy Region Mid-Atlantic Public Affairs.

Eight men from the 1968 Hospital Corps School Company 27 and four spouses visited the with Naval School of Health Sciences (NSHS) San Diego to celebrate their 40 year anniversary. The visitors are pictured with NSHS military staff (L-R) LCDR Steven Parks, Department Head, Educational Support Services; CAPT Linnea Axman, NSHS Executive Officer; CDR Carolyn Marquez, NSHS Program Director, Medical Laboratory Technician Program; and HMCS Pete Villanueva, NSHS Manpower Officer. Photo by LCDR Steven Parks, USN

Navy Supports STEM Organization Legacy Awards Gala

VADM Adam Robinson, Surgeon General of the Navy and VADM Kevin McCoy, Commander, Naval Sea Systems Command, teamed up to attend the third annual Benjamin Banneker Legacy Awards Gala held 21 November at the Historic Capitol Hilton Hotel in Washington, DC.

The gala, whose theme was, "alignment, accountability, and leadership," honored and encouraged African Americans to pursue science, technology, engineering, and mathematics (STEM) careers and fields of study.

VADM Robinson, himself a 2007 Benjamin Banneker award winner and a keynote speaker that evening, told an audience filled with representatives from historically black colleges and universities, STEM organizations and high school students two things: The Navy is committed to building a culture that truly values diversity, and the Navy is looking for those willing to serve their country in the field of medicine.

"I've traveled the country speaking to hundreds of premed students on college campuses in an attempt to recruit the next generation of scientists and engineers," Robinson said. "I've found the field is rich with the raw material needed to harvest a magnificent crop of scholars, physicians, and scientists. We must pledge to work and cultivate our students of color and help them to achieve success," he continued.

VADM McCoy, also a keynote speaker at the gala, seconded the Navy's commitment to growing a more diverse force.

"Diversity strengthens organizations. It increases productivity, fosters creativity and innovation, and enhances teamwork," McCoy said. "Diversity is not only morally right; it is a business imperative if we are going to remain a relevant and capable Navy at every rank and reflect the changing demographics of American society."

McCoy pointed out the nation currently has about 500,000 highly-trained African Americans professionals employed in STEM fields across the nation. He also expressed a desire to tap into this treasure trove of talent on behalf of the Navy.

"We want you. We need you. If you're an engineer and you're interested in joining the Navy, I'll start you out at $60,000 right here right now," he told the audience.

Throughout the evening award winners gave inspiring examples of how they were using their STEM talents in everyday life. These examples included addressing environmental concerns like pollution, wildfires, global warming, energy independence, and climate-related disasters. They also outlined how these environmental threats are inextricably linked to the STEM fields.

Robinson agreed the success of any organization is directly tied to its people. However he wants more of those successful people to be African American, even if it means leaders and those in positions of influence must become more proactive in providing encouraging examples to young African Americans considering careers in science.

Robinson summed up these responsibilities with a call to action. "Everyone comes into this life with a gift to offer and a strong purpose to be served," he said. "We must use our influence to uncover these gifts and these purposes that lie in the hearts of young African Americans."

–Navy Total Force Public Affairs.

NHB Internal Med Dept head recognized as Navy Internist of the Year

CDR Mark Dick, head of Naval Hospital Bremerton's (NHB) Internal Medicine Department, was recently selected as the top Navy Internist of the Year, receiving the Sparks Award for Outstanding Internist of the Year at a Family Medicine or Non-Teaching Hospital. The award is the only one presented annually by the Navy Chapter of the American College of Physicians.

CDR Mark Dick is congratulated by CAPT Mark Brouker, Naval Hospital Bremerton Commanding Officer. Photo by HM1(SW) Julie Jorgensen, USN

Dick was nominated by NHB's Director of Medical Services, CAPT Ronald Dommermuth for the award, and as such has continued a minor tradition of sorts by having the award associated with NHB. The previous Internal Medicine head, CDR Eric Rasmussen was recognized, as was CDR Dave Murphy, who is currently one of NHB's new pulmonologists.

"It is always tremendous to be recognized by your peers," said Dick, who has been at NHB for almost 3 of his 15 years in the Navy. "Past recipients have gone on to be leaders in the internal medicine community."

According to Dommermuth, Dick is intricately involved in disease management and population health initiatives.

–Story by Douglas H. Stutz, NHB Public Affairs.

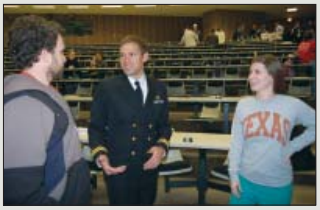
Sharing Opportunities in Navy Medicine

Navy Recruiting District San Antonio understands the urgency of finding qualified doctors, nurses, dentists, clinical counselors, and other medical professionals to serve in the Navy. The talented medical recruiters work tirelessly each day to search for those students that will choose the educational and service opportunities that the Navy has to offer.

The district recently hosted a visit by LT Andrew Baldwin, best known for his reality show stint as ABC's "The Bachelor." Not only is Baldwin an undersea medical officer but also an Ironman triathlete, Navy diver, and humanitarian. Baldwin was raised in a family that always placed service to country at the forefront.

On his tour, LT Baldwin spoke at Baylor University in Waco and the University of Texas Health Science Center in San Antonio telling his story. He also shared home videos of treating children in remote villages of Laos and talked about the unprecedented opportunities the Navy has given him in his career.

"Baldwin is the complete story, he shares his incredible opportunity to learn and to serve," according to LT Vinny Maysonet, Medical Recruiter for NRD San Antonio. First while Dr. Baldwin was an ROTC student at Duke University and later attending the University Of California San Francisco School Of Medicine before becoming a surgical intern at Naval Hospital San Diego.



LT Andy Baldwin talks with University of Texas Health Science Center medical students. Photo by Carol C. Moore

"Navy medicine is the most incredible experience for any healthcare professional. There is no other corporation that compares in terms of scope of practice, camaraderie, and ability to lead the most rewarding lifestyle." Maysonet continues saying, "Andy is a huge asset to Navy medicine. He is a charismatic physician."

While visiting San Antonio LT Baldwin took the time out of his busy schedule to also stop by the Dell Children's Medical Center in Austin as well as Christus Santa Rosa Children's Hospital and Methodist Children's Hospital in San Antonio. He is passionate about the hospital visits and always includes them in his scheduled trips. Baldwin is the perfect tool in the world of medical recruiting. He continues to dedicate his service to assist others in making valuable decisions about their medical careers as well as serve our community as a goodwill ambassador for Navy medicine.

–Story by Carol C. Moore, Public Affairs Officer, Navy Recruiting District San Antonio.

Nurse Recruiting and Retention Team Recruits the Best and Brightest

Navy Nurses at Naval Hospital Camp Lejeune kicked off an initiative in collaboration with HMCS(FMF) Terry Anderson from Navy Recruiting District Raleigh, in support of Nurse Corps recruitment efforts. East Carolina University School of Nursing (ECU) supported the recruitment effort by graciously providing the opportunity for the nurses to share their stories and discuss their varied career paths. The recruiting team, led by CDR Angela Gardner and CDR Brad Buchanan, addressed more than one hundred Bachelor in Science (BS) students. They spoke with students addressing their questions and concerns.

During the visit to ECU, LT Alicia Weissgerber and LT Sheila Almendras-Flaherty shared their personal stories, experiences and reasons they chose to make nursing and the Navy a life-long career. Their participation in this event helped raise awareness about the opportunities and benefits afforded to nurses in the military. According to Anderson, the visit by the nurses was a tremendous help because "they provided their real-life Navy testimonials."

The senior nursing students were provided the opportunity to ask questions and interact with the team. The team was impressed with the number of students interested in the nursing profession and genuinely interested in the Navy Nurse Corps. "Sharing real world experiences very much personalizes the concept of being a Navy nurse. The students see that we are generalists, advanced practice nurses, male, female, single, married, single moms, and even grandmothers. They develop an understanding that Navy nursing is truly multi-faceted and the opportunities for continued education and service from hospitals, to ships, to service with the Marines, offers both a unique and rewarding experience," said Gardner. As a result of the visit and three follow-on recruiting efforts by other team members six highly motivated students were recruited and plan on pursuing a career in the Navy.

CDR Brad Buchanan accompanied Anderson to the University of North Carolina, Wilmington for the inaugural visit for the recruiting team. They attended a career fair which provided information for senior college students preparing to enter the job market. "Actively engaging our present day students ensures the future successes of our Navy Nurse Corps and Navy medicine. We have the opportunity to personally and professionally impact those students in a very positive manner. I cannot think of anything more important," said Buchanan. By interacting directly with nursing students, CDR Buchanan and HMCS Anderson were able to bring four potential direct accession nurses into the recruiting pipeline.

HMCS(FMF) Anderson and the Naval Hospital Nurse recruiting and retention team continue to strive to recruit the best and brightest and will continue their collaborative efforts throughout Eastern North Carolina.

–Navy Recruiting District Raleigh Public Affairs.

Corpsman Earns "Combat V"

A corpsman with the 2nd Marine Logistics Group's 2nd Medical Battalion was awarded the Navy and Marine Corps Commendation Medal with a combat distinguishing device in an awards ceremony 19 November 2008.

HM1 Casey A. Wheeler earned the medal during Operation Rustam, 30 September 2007, while assigned with Military Transition Team 0142, which was partnered with 2nd Battalion, 4th Brigade, 1st Iraqi Army Division.

BGEN Juan G. Ayala (L), CO, 2nd Marine Logistics Group's, is shown with HM1 Casey A. Wheeler. Photo by 2nd Marine Logistics Group Public Affairs

During the battle, the team received three casualties to include one KIA. The first casualty was an IA soldier who was shot in his right leg. After controlling the bleeding, Wheeler returned the IA soldier to the fight.

Shortly after, one of the team members, GSGT Jerome Murkerson, Jr., took a fatal gunshot to the head. Without hesitation, Wheeler attended to the Marine while under fire and moved him to a covered position.

He quickly established a casualty collection point and began coordinating with a coalition quick reaction force to evacuate the casualties from the combat zone.

The team soon took another casualty. Another teammate, an Army first lieutenant received a gunshot wound to his right leg. Wheeler treated the wound, enabling the lieutenant to continue in the fight.

He then continued to assist at the established casualty collection point and helped coordinate water and medical re-supply to sustain the combat readiness of the team through the 6-hour battle.

–Story by 2nd Marine Logistics Group (FWD) Public Affairs, Marine Corps Base, Camp Lejeune, NC.

CAPT Mark B. Lyles, DC, was awarded the AMSUS 2008 Carl A. Schlack Award 12 November at the AMSUS annual dinner. This award honors the late CAPT Carl A. Schlack, DC, USN (Ret.) whose accomplishments initiated and firmly established dental research in the Navy. As an educator and researcher, Schlack's contributions significantly enhanced the stature of the dental profession.

Nurse Corps Officer Awarded Bronze Star

LCDR Keith B. Hoekman, a Naval Health Clinic New England (NHCNE) nurse practitioner, was presented the Bronze Star by CAPT D. Elizabeth Nelson, CO. Hoekman earned award for Exceptionally Meritorious Service for actions in support of Operation Enduring Freedom. LCDR Hoekman served as the Medical Officer for the Provincial Reconstruction Team (PRT) in Ghazni Province, Afghanistan, from 21 March 2007-19 March 2008. He provided primary and trauma care for U.S., Afghan, and coalition forces, from a Level 1 Aide Station staffed with 4 medical personnel and a total of 80 personnel in the PRT unit. He also worked closely with the Afghanistan Director of Health, and was responsible for the development of the local healthcare sector for the country, which included education of the Afghan physicians and healthcare workers, leadership development of medical staff, especially in trauma care, and the construction of 12 medical clinics and an emergency room for the Province Hospital. The mission also included equipping the facilities with supplies and equipment and educating the staff in their proper use and care.

CAPT Nelson presents the Bronze Star to LCDR Hoekman. Photo by Kathy L. MacKnight, NHCNE Public Affairs

Upgrading the facilities and educating the providers, has allowed the Afghan medical staff to better treat and care for their own police and army. Before these changes occurred, trauma care given from the Level 1 Aide Station was better than at the Provincial Hospital. This was demonstrated when 7 members of the Afghan Army, with 19 gunshot wounds between them, sought care from the U.S. facility, rather than their own hospital.

–Story by Kathy L. MacKnight, Naval Health Clinic New England Public Affairs.

FYI - http://www.warriorcare.mil/ is a warrior care website that consolidates all the different pieces our warriors need to know.

Gazing along the Portsmouth waterfront during the holidays, one unmistakable light shines out: the star illuminating Hampton Roads' first skyscraper, Naval Medical Center Portsmouth. This year marked the 49th anniversary of the star.

In 1959, the new naval hospital was nearly completed. At 18 stories high, it was the tallest welded-steel building between New York and Miami. The crowning of the 4-year construction took place on 1 December 1959 when a large star was placed on the roof of the elevator penthouse. Made of electrical conduit supporting 10 8-foot fluorescent light bulbs, the 5-pointed star rested 250 feet above ground, becoming the highest holiday decoration in the area.

In 1993, a new star was fabricated to replace the original. It's the one still in use today, and measures 25 feet from point to point. The star is illuminated every night through 2 January. Photo by MC2 William Heimbuch, USN

Members of the Pensacola Oak Leaf Club and Naval Hospital Pensacola's First and Second Class Petty Officer associations fill holiday care packages for deployed hospital staff personnel around the world. Photo by MC1(AW) Russ Tafuri, USN

Former U.S. Marine Corps drill instructor turned Golden Globe-nominated actor R. Lee Ermey joins Santa Claus to put toys into the "Toys for Tots" donation box at Naval Medical Center San Diego. Ermey visited the hospital to support the program and visit with staff and service members. Photo by MC2 Greg Mitchell, USN

Commander, Naval Medical Center San Diego RADM Christine S. Hunter, and CAPT Gregory Blaschke, Medical and Surgical Simulation Center (MSSC) medical director, conduct a ribbon cutting ceremony to commemorate the grand opening of the hospital's MSSC. MSSC is a new facility created to provide medical personnel the oportunity to test their skills on simulated patients. Photo by MC2 Greg Mitchell , USN

Suffolk, VA. Wreaths are placed at the Alfred G. Horton, Jr., memorial Veterans Cemetery to honor fallen veterans as part of a Wreaths Across America Ceremony. Wreaths Across America is a program to remember the fallen, honor those who serve, and teach children the value of freedom. Photo MC3 Mandy Hunsucker, USN

"Sparky the Fire Dog" from the National Fire Protection Association (NFPA), visits Christian W. Bergman and other pediatric patients at Naval Medical Center San Diego (NMCSD) on Christmas Eve. Sparky passed out gifts and wished service members and their families happy holidays. Photo by MC2 Greg Mitchell, USN

Iraqis Send Aid to California Fire Victims

A group of Iraqi soldiers stepped up to help California residents victimized by recent wildfires that raged throughout the state.

Iraqi Army COL Abbas Fadhil, Besmaya Range Complex commander, and his team of "Abbas' Eagles" raised $500 for wildfire relief. "We want to send a message to the American president and the American people," Abbas said. "We feel that we are a family—one body. When one part of the body suffers, the other parts suffer, too."

This is the fourth donation the soldiers of Besmaya have sent to the American people. In September, they raised $1,500 for victims of hurricanes Gustav and Ike. The Eagles also donated $500 to the National 911 Memorial.

–American Forces Press Service

CDR Angelia Elum-O'Neal hands an Operation Smile patient to LCDR Maria Norbeck after a successful surgery. Photo by MCSN Joshua Adam Nuzzo, USN

IT2 Andrew Bryson teaches Sister Helena at the Carmelite Sister Convent how to surf the Internet. Photo by MCSN Joshua Adam Nuzzo, USN

Continuing Promise 2008 Mission Complete

USS *Kearsarge* (LHD-3), along with various embarked units, departed Georgetown, Guyana 22 November to begin transit back to its homeport in Norfolk, VA, concluding 4-months at sea in support of the Caribbean phase of Continuing Promise (CP) 2008. *Kearsarge*'s mission was to conduct joint civil-military operations including humanitarian and civic assistance (HCA). These operations included veterinary, medical, dental, and civil engineering support to six partner nations and to send a strong message of compassion, support, and commitment to Central and South America and the Caribbean. "An incredible journey seems like an understatement for this mission," said CP08 Mission Commander, CAPT Fernandez "Frank" Ponds. "The men and women of Continuing Promise have given their sweat, their tears, and at times, their blood to make this mission successful. We have broken through many barriers; language, cultural, and government, to reach out to our neighbors in Central and South America and the Caribbean in a gesture of goodwill and friendship. The bonds we have made will last for years to come and only grow stronger with future missions to the area."

During the deployment, the CP 2008 medical contingent of more than 150 joint military and international military medical professionals and non-governmental organizations (NGOs), worked along side host nation officials to treat more than 47,000 primary care patients, dispense more than 81,300 prescriptions, provide veterinary care to nearly 5,600 animals, and conducted more than 198,600 medical, dental, and eye services. In addition to the primary basic medical care provided by the CP 2008 team, 221 patients were flown to *Kearsarge* for shipboard surgeries, including hernia repair and eye surgery. One of the mission's most memorable surgeries involved two 8-year-old twin boys from the Dominican Republic who received eye surgery to correct strabismus, a condition where the eyes do not properly align with one another. "The boy's have been dealing with this problem since they were born," said Joselyn Altagracia Carmarena Vargas, the twins' mother. "This blessing has been a long time coming, and our family is very grateful for everything that is being done for us." For most of the doctors on the CP team, the smiles, hugs, and handshakes have made this mission worthwhile. "It gives me great satisfaction to be able to have helped these boys in a way no one else could,"

said CDR Brian Alexander, an ophthalmologist. "The smiles on the faces of the twins and their mother were one of the biggest rewards I could have received." During the ship's visit to Nicaragua, surgeons from Operation Smile performed more than 20 cleft lip and cleft pallet surgeries. While in Guyana, the final stop in the CP 2008 mission, *Kearsarge* was also able to tackle unforeseen medical emergencies. Pilots from Helicopter Sea Combat Squadron (HSC) 28, Detachment 5, conducted an at-sea medical evacuation of a heart attack victim aboard a nearby vessel. Air crew members from Marine Heavy Helicopter (HMH) Squadron 464, rendered emergency transport assistance at Kumaka District Hospital in Santa Rosa to a young girl suffering from appendicitis. In addition to the medical care provided by the CP team, Navy Seabees attached to Construction Battalion Mobile Unit (CBMU) 202, and civil engineers from the Air Force's 5th Civil Engineer Squadron's Prime Base Emergency Engineer Force completed various construction and renovation projects in each of the countries visited during the mission. In all, the joint-military engineering team built 3 schools, renovated 10 schools, clinics and hospitals, conducted 10 park/community center renovations, and performed 5 infrastructure related projects. "I am very proud of the projects my engineers were able to accomplish in the short periods of time that we had to work. To build three school facilities from the ground up was an amazing accomplishment," said MAJ Thomas Defazio, officer in charge of CP 2008 engineers. "We all felt privileged to be a part of this mission. The teamwork amongst the various organizations that came together was unbelievable. I also greatly enjoyed the opportunity to work with the Seabees again. I think our organizations have much to learn from each other. We came as two separate units but left as one team." At each stop on the deployment, *Kearsarge* sailors assisted the engineering team by participating in volunteer community relations projects at the sites and offering extra hands to help with landscaping, construction, painting, and building playgrounds. The sailors also took great pride in getting to know the communities they worked in by organizing several sporting events including basketball, soccer, and cricket. Throughout the deployment, *Kearsarge* distributed hospital furniture, clothing, books, and medical supplies through the Navy's

Anesthesiologist Enrique Abreu, Project HOPE, prepares twin brothers from the Dominican Republic for eye surgery. The boys were born with a condition know as strabimus, or crossed eyes. Photo by MC2 Gina Wollman, USN

LCDR Maria Norbeck helps locals off a helicopter after returning from their surgeries aboard *Kearsarge*. Photo by MCSN Joshua Adam, USN

USS *Kearsarge* (LHD-3) underway off the coast of the Dominican Republic. Photo by MC3 William S. Parker, USN

CDR Brian Alexander, an ophthalmologist, performs eye surgery on a 3-year-old girl whose eyelids had been fused together since birth. Photo by MC3 Maddelin Angebrand, USN

LCDR Kenn Norris checks the throat of a little boy at the Couva District Health Facility Trinidad and Tobago. Photo MC3 David Danals, USN

CDR James Hill performs dental work on a patient at Kumaka District Hospital, Guyana. Photo by MC2 Erik Barker, USN

Project Handclasp. The ship also hosted numerous dignitaries, including presidents, prime ministers, U.S. ambassadors, and ministers of health and defense. Project Hope brought volunteers from numerous career fields, including pediatricians, nurses, nurse practitioners, general surgeons, and anesthesiologists. The volunteers' work ranged from patient tracking to helping coordinate large patient flow at the treatment sites and working with Navy surgeons in the ship's operating rooms to medical counseling at the treatment sites. "The men and women who make up the CP team come from around the globe, from different military branches and different NGOs, but the one thing they all have in common is a desire to help their fellow man and make a difference in the lives of others," said Ponds. "They each bring a uniqueness to the mission and have worked together seamlessly to make this deployment a tremendous success." During its 4-month deployment, *Kearsarge* completed HCA missions in Nicaragua, Colombia, the Dominican Republic, Trinidad and Tobago, and Guyana.

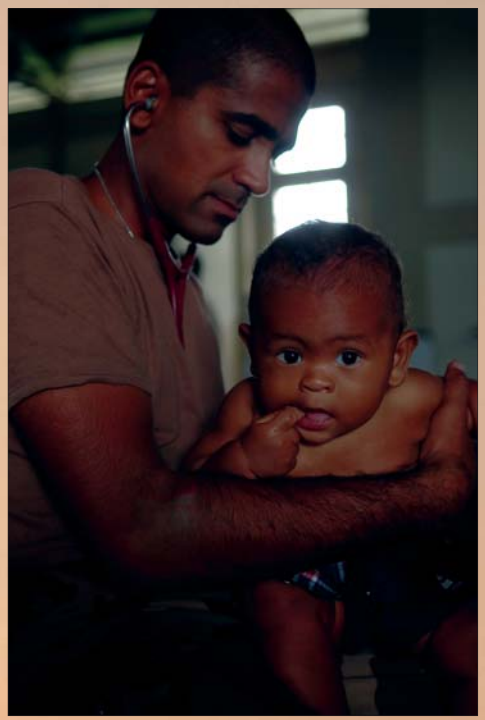
Wasp-class amphibious assault ships like *Kearsarge* are designed with a variety of expeditionary mission capabilities, including rapid, projected humanitarian assistance worldwide. They also have the physical capacity to transport large amounts of medical and engineering supplies and equipment to most locations around the globe. One month into the mission, *Kearsarge* put those capabilities to the test when it was called upon to divert its HCA operations in Colombia and assist with humanitarian assistance/disaster relief (HADR) operations in Haiti after the country was struck by four tropical storm systems in less than a month. *Kearsarge*'s ability to rapidly move personnel and cargo by helicopter and landing craft made it the ideal platform to support the humanitarian relief mission on short notice. Embarked Marine and Navy helicopters flew more than 100 missions and landing craft units transported more than 30 loads of supplies. These operations led to the timely delivery of more than 3.3 million pounds of food, water, and other relief supplies. "I could not have been more proud of *Kearsarge* sailors and all of the embarked units who have supported this mission," said CAPT Walter Towns, commanding officer, *Kearsarge*. "No one hesitated

to do what was necessary to keep this mission on course. We had men and women working in the rain and in the heat, giving their all everyday just to put a smile on the faces of those they were helping. They never once asked for thanks or recognition. For them, it was about being a part of something bigger. This is a deployment they will never forget." *Kearsarge*'s mission exemplified the United States Maritime Strategy which emphasizes deploying forces to build confidence and trust among nations through collective maritime security efforts that focus on common threats and mutual interest. Embarked units and organizations aboard *Kearsarge* for CP included Commander, Amphibious Squadron 8; Fleet Surgical Team 4; U.S. Public Health Service; Navy Construction Battalion Maintenance Unit 202; Air Force Civil Engineering Squadron 5's Prime Base Engineer Emergency Force; contingents of medical personnel from the armed forces of Canada, The Netherlands, France, and Brazil; Navy Assault Craft Unit 2; Naval Beach Group 2; U.S. Navy Maritime Civil Affairs Squadron 2; Helicopter Sea Combat Squadron (HSC) 28; and Marine Heavy Helicopter Squadron (HMH) 464. NGO organizations included International Aid, Operation Smile, and Project HOPE.

–Story by MC1 Amy Kirk, Continuing Promise 2008 Public Affairs.

LT Carmen Harmon, NC, shares a computer game with children at a medical civil assistance project in Santa Rosa, Guyana. Photo by MC3 Maddelin Angebrand, USN

LT Johnny Cosby conducts an eye exam at a medical clinic set up for the Caribbean phase of Continuing Promise. Photo by MCSN James G. Pinsky, USN



LCDR Sugat Patel provides medical care to a Dominican child at the Bayaguana Sports Complex. Photo by MCSN Ernest Scott, USN

Confusion over Conversions

Clarification on the Military-to-Civilian to Military Mandates

CDR Robert S. Fry, MSC, USN
LCDR Robert L. Anderson, MSC, USN

In October 2008 the 2009 National Defense Authorization Act (NDAA) became law(*1*) and upheld the prohibition on medical military-to-civilian (Mil-to-Civ) conversions. Or did it? According to two published sources, *Federal Times* and *Navy Times* (3 November 2008) (*2,3*), "Congress lifted a ban on converting medical and healthcare jobs held by uniformed military members…." These articles were erroneously published after the prohibition was maintained in the 2009 NDAA, adding confusion to the implementation of the conversion mandates.(*4*) We understand that many in Navy medicine can tell stories about how the Mil-to-Civ program affected their commands and opinions about the impact on healthcare costs, access, and quality vary greatly. The purpose of this paper is not to evaluate the efficacy of the program, but to clarify and educate the readers on the Mil-to-Civ mandates and the way ahead for Navy medicine. To understand these mandates, we need to understand where we were and where we are.

The Beginning

Since the start of the global war on terror, military services have been experiencing significant stressors on the military forces (the Force). With sustained operations in Afghanistan and Iraq, the situation has only been confounded with the increased demand for individual augmentation, humanitarian assistance, and disaster relief missions. In 2003, to alleviate some of the strain on the Force, the Department of Defense (DOD) leadership began to socialize the Defense Transformation Act for the 21st century which requested permission from Congress to initiate the Mil-to-Civ conversion program. According to then Deputy Secretary of Defense, Paul Wolfowitz, "…we have some 320,000 uniformed personnel doing essentially non-military jobs."(*5*) The Department's Under Secretary for Personnel and Readiness, Dr. David Chu, told Congress that "Because of conversions, the Navy…will be able to reduce their authorized military end-strength without any loss to combat capabilities. In fact, savings from these conversions will result in increased force effectiveness as savings are applied toward force modernization and other compelling needs."(*6*)

Starting in 2005, Navy medicine underwent three significant Mil-to-Civ reprogramming mandates that ultimately sought to convert 7,755 uniformed billets to civilian billets by the end of fiscal year (FY) 2013. The impact of the force structure transformation went beyond whether a uniform is worn by a staff member or not. In fact, the FY06 and FY07 National Defense Authorization Acts (NDAA) required the Service Secretaries, prior to execution, to certify to Congress that military medical or dental conversions would "not increase cost or decrease quality of care or access to care."(*7,8*) From FY06 to FY08, the Secretary of the Navy certified almost 99 percent of the 3,712 billets identified for conversion.

Mil-to-Civ Mandates

The first Mil-to-Civ conversion mandate began with Program Budget Decision-712 (PBD-712), which directed Navy medicine to turn 1,772 military medical billets to civilian effective in FY05. In response to PBD-712, the Bureau of Medicine and Surgery's (BUMED) Human Resource Office (M-1) developed a strategy to identify and execute the conversion of these 1,772 billets. By examining personnel assignments and the demands of operational deployments, and beneficiary healthcare, a team of manpower analysts developed a list of potential positions eligible for conversion. All 1,772 billets selected for conversion were deemed to be above Total Health Care Support Readiness Requirements (TH-CSRR), and, therefore, exceeded what

Navy medicine needed to satisfy its operational requirements. The list was forwarded to the regional commanders for review with instructions that any billet removed from the list had to be replaced with an alternate. The same process was repeated with the next two iterations of conversion mandates.

The DOD's second mandate evolved through an Enhanced Planning Process (EPP) that examined Program Objective Memorandum (POM) 2006 issues such as military-to-civilian conversions. The EPP led to the requirement for an additional 3,643 billets be converted between FY06 and FY11. The third DOD mandate was directed as a result of the Medical Readiness Review (MRR), a part of the Quadrennial Defense Review (QDR), which identified non-military essential billets. The MRR required another 2,340 billets be converted between FY08 and FY13. Table 1 illustrates the billets converted by mandate and fiscal year. Eighty percent of the billets identified are corpsmen (including former dental technicians), non-medical billets account for less than 1 percent, and the remaining are distributed among Navy medicine's different officer corps.

Table I

Fiscal Year	PBD712 Conversions	EPP Conversions	MRR Conversions	Total Conversions
2005	1,772	0	0	1,772
2006	0	215	0	215
2007	0	679	0	679
2008	0	802	209	1,011
2009	0	789	234	1,023
2010	0	755	246	1,001
2011	0	403	250	653
2012	0	0	729	729
2013	0	0	672	672
TOTAL	1,772	3,643	2,340	7,755

The Hiring Strategies

DOD's and BUMED's initial hiring guidance, promulgated through regional commanders, allowed commanding officers the flexibility to hire needed specialties, instead of replacing exactly what had been converted. In some instances, commands reviewed their needs, staffing and beneficiary populations, and opted not to hire to all converted military billets. The funding for these billets was made available for other priorities within Navy medicine. This optimization model was consistent with the intent of the overall program as first socialized by DOD leadership. Other military positions that were not replaced with civilians include the billets from the closure of Naval Hospital Keflavik, Iceland and Branch Naval Health Clinic La Maddalena, Italy.

The Prohibition and Civ-to-Mil Mandate

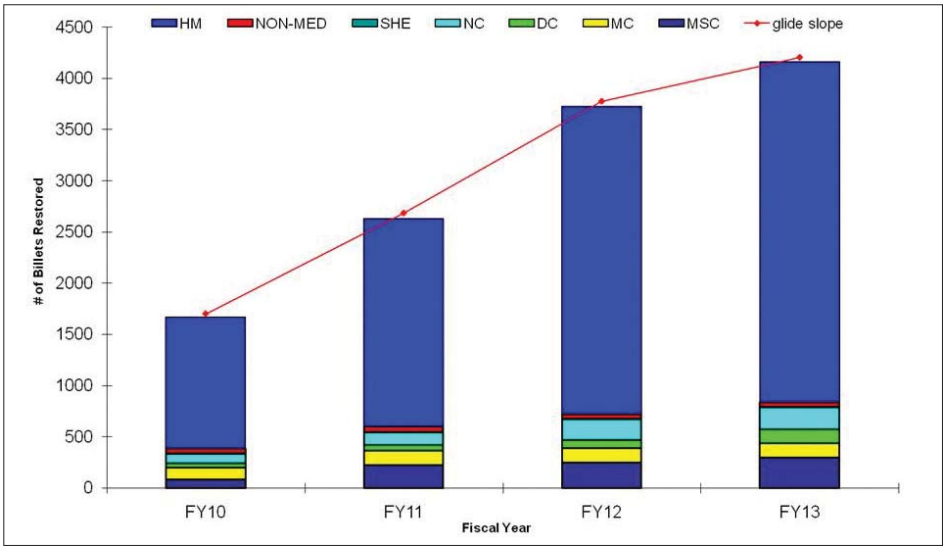
In 2008, Section 721 of the FY08 NDAA became law. Section 721 repealed the certification requirements from the FY06 and FY07 NDAAs, but most important, it prohibited the further conversion of military medical and dental positions to civilian medical and dental positions through 30 September 2012 (FY12). (*9*) In addition, the bill required the restoration of all positions converted in FY05 through FY07 for whom a civilian had not yet been hired by the end of FY08. As of 1 October 2008, the four BUMED regional commanders reported that all the FY05 to FY07 planned civilian conversions have been hired. The FY08 NDAA did not address the nearly 700 billets identified for conversion throughout Navy medicine in FY13. The prohibition became effective when the President signed the bill into law on 28 January 2008. Prior to the January signature, a total of 61 civilians were hired from the FY08 conversions quotas.

The House and the Senate considered two different approaches for FY09 NDAA to address the Mil-to-Civ program. On one end the Senate Bill (S. 3001) proposed to repeal the FY08 NDAA prohibition and "revive" the FY07 NDAA certification requirements, essentially again permitting military medical Mil-to-Civ conversions. In direct contrast, the House Bill (H.R. 5658) proposed to indefinitely extend the FY08 NDAA prohibition of military medical Mil-to-Civ conversions. Congress did not include either of the provisions in the FY09 NDAA presented to the President, which was signed on 14 October 2008; consequently, the prohibition remains in effect until FY13.

The Restoral Plan

With the success of the regional commands hiring all the FY05 to FY07 planned conversions to include the 61 FY08 hires prior to the prohibition, only 4,204 billets remain from FY08 to FY12 to be restored. This is necessary because previously submitted programming actions removed the planned conversions from Navy medicine's manpower rolls; actions that now require restorations. Figure 1 is the proposed restoral glide slope

Figure 1



as of October 2008. The glide slope was developed taking into account the ability to retain, recruit, and train new accessions. The plan for the 1,821 restorals due in FY08 and FY09 is a steps phase in of the billets over fiscal years 2010 through 2013. This phasing plan permits the time needed to recruit and train military medical personnel for these billets. To restore all 1,821 billets essentially means Navy medicine would have several hundred gapped billets until "encumbered." The FY10 through FY12 billets will be restored in the fiscal year they were planned for conversion. The restorals will reflect the composition of the military positions converted, i.e., 80 percent of the restorals are expected to be corpsmen. One percent is non-medical billets, and the remaining is distributed among Navy medicine's different officer corps.

The Way Ahead

Due to the nature of the Mil-to-Civ-to-Mil program execution, billet gaps exist and are expected to increase as the billets are restored. BUMED staff is working with regional commanders to refine a "bridging strategy" to mitigate the potential staffing shortage impact by funding temporary staffing solutions.

The military billets have been restored, so an opportunity exists to evaluate the skill mix required to meet current and future healthcare and readiness demands. The flexibility in changing skill mix (or the quality of the billets) is a primary tenet of the Mil-to-Civ program. Navy medicine's challenges are to contemplate what new accession demand signals will be required over the next few years to meet the operational requirements without losing focus on healthcare costs, access, and quality. Although the majority of the conversions are being restored, it is important to note that the future of the Mil-to-Civ program is not completely defined. There are nearly 700 military medical billets still programmed for conversion in FY13, and Congress has not clarified their intention whether to continue or repeal the prohibition. Standby for further clarification.

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Corpsmen Are Not Chefs

Dennis Noah

In combat situations you return to the basics of survival: food, staying dry, and so forth. Food is a large aspect of life, especially when you spend days on end eating out of these little green cans with dates on them going back to the Korean War. Also on extended operations in the field, we were particularly dependent upon helicopter resupply missions that were not always dependable because of the combat situation.

On one mission, they shipped us out by helicopters and as often occurred, we walked and walked and walked. The military term is a "forced" march. I do not know what is so forced about it. I certainly was not able to lag behind and be left in the middle of the jungle somewhere. It was not necessary to force me to follow the guy in front of me. So on my part anyway, it was a "voluntary" march. I had no hope in finding my way back alone.

I am not certain exactly how long we walked, but we started out in the morning, saw an entire day, then a night, and another sunrise, then another afternoon before we arrived at our destination. We marched over hills, through creeks, rice paddies, and even walked for a few hours down a railroad track. We were told to be quiet, but I have to tell you something. We did not talk but we were not quiet. We had weapons straps clanging, ammo bandoliers knocking against each other, and the clumping of 100 sized 11 to 13 jungle boots. We were not exactly stealthy but we did not talk.

We had been out in the field for (no surprise here) a few days before we took our hike. Our little green cans were mostly gone when we started our walking tour of Southeast Asia. They were not able to re-supply us so we had little chow. We were tired, wet, and famished. As an old friend of my father used to say on our fishing outings: "We had wet butts and hungry guts." I was so tired that the whole event seemed like an out of body experience. I was walking in a stupor from the fatigue and hunger.

Then, all of a sudden, our dreams came true. We walked into this clearing at dawn on the second morning and there were cooks, tables, and on these tables were green containers with hot chow. The cooks were Army dudes but what the heck, we were desperate. We thought we had died and gone to heaven. The Marine Corps did not provide hot chow out in the field. And I mean never.

I understand that the Army did supply hot chow on occasion in the field and at times beer. The only hot chow we had came in those green cans and was heated by C4.* We did receive beer in the field once but it came in the form of manna from heaven like Moses in the desert. By this I mean the beer was thrown from helicopters flying at 60 knots and 300 feet. You ever had 20 cases of canned beer dumped out of helicopters in the jungle on your head? Well, let me tell you, a beer can with a forward speed of 60 knots falling on you from 300 feet really hurts. This was our first and last beer run in the field and it was not particularly successful. I didn't even like beer so why did I have to be smacked with beer cans from on high? It did not seem fair to me.

Anyway, as luck would have it, the senior Army NCO said that he did not have enough for us because he was waiting for the Army patrol to return. He apologized with sincerity. He said that he could give us some

*Military plastic explosive.

cornflakes. They were in these little cardboard boxes with the perforations you opened and poured milk into them. We gladly accepted. Of course, he had no milk to give us. He did not have any sugar either. I poured the warm halazone laden brown, muddy rice paddy water from my canteen onto my corn flakes. Man did this stuff taste awful. It literally looked like mud and tasted like, well you know what.

After the scrumptious breakfast, we continued our walking tour of Vietnam or wherever we were. During the late afternoon, we came to a large abandoned village. My platoon was sent in to occupy it and dig in for the night. We looked for McDonald's but apparently it had not yet opened in this village. We were flat out starved.

Then we heard this quacking. I mean there were ducks in this place! You can eat ducks, right? We did not wish to shoot them, as it would make big holes in them. So off we went, K-Bars and bayonets in hand. The great hunters were going to slay these ducks and live off the land like Daniel Boone. Marines should have no trouble slaying these little critters, right? Wrong! There were two-dozen Marines chasing them around for over an hour—battle-hardened warriors of our country trying to kill these ducks.

It was not funny at the time as we were hungry. Now thinking back upon it, we must have looked like the Keystone Kops chasing these little things. We finally killed six of them. There were two others but they are probably still running and laughing. Now what? Who was going to clean and cook them?

They all looked at me, the corpsman, to prepare the feast. I was in charge of health. Food was part of health. Correct? They thought it was perfectly logical that I should be the chef. It seemed like quite a stretch to me, but I agreed. I did hunt growing up in the Ozarks and knew how to clean ducks. However, cooking them was another matter. Mom always handled this part.

In the village, there was a large hut with a large cooking area and even pots and pans and a wood grill. I would not bestow upon it the respect to call it a kitchen but it would do. On the other hand, I was no Julia Child either. There was even rice. So I butchered the ducks, threw them in water and boiled them for a couple of hours. I then added some rice and made a rice soup with pieces of duck. It smelled horrible. It even looked worse. Have you ever seen the stuff that is pumped out of a boat's or RV's holding tank? It looks like watery milk chocolate pudding. Well this is exactly what my cooking prowess had produced with the same consistency. It smelled about the same.

I was going to throw it out, but they were hungry so they ate it. I did not. I would rather have eaten mud but they devoured it with enthusiasm and thanked me. Little did we know that the VC ducks had a surprise in store for us.

Well about 0200 in the morning in the pitch black, I heard a moan, then another moan, then another moan, then about 20 more. Then I heard my guys puking from the other end. The entire platoon was sicker than you can imagine. I was not sick, of course, as I refused to eat my own cooking. I had given them food poisoning.

For the next two days I gave them all kinds of medications including antibiotics to heal them. They marched with their legs spread out to the side (like a cowboy who had ridden horses for 60 years), they were doubled over, and they had these anguished looks on their faces. They kept running into the brush and asking for those tiny rolls of toilet paper. We promptly ran out of the latter. The officers wanted to know what happened. With the innocence of a newborn baby, I said, "I really do not know, sir. It must have been bad water, sir."

Yeah, that was it. Bad water. They bought it and I never told them what really happened. I figured I would end up in Portsmouth [Naval Prison] for 5 years if I told the truth. I informed our leaders that I had it under control and they should not worry.

Slowly, my guys began to stand upright and walk normally like humanoids again. By the third day, everyone was well again in H Company.

The only good thing about this ending was that the platoon was no longer hungry. This worked out perfectly as we did not get resupplied for 2 more days. I was hungry but endured. I was never asked to cook again.

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Is Navy Medicine Ready for Servant Leadership?

LCDR Frank H. Stubbs III, MSC, USN

Since 1775 and the days when hospital corpsmen were known as "Loblolly Boys" and men sailed on wooden ships, Navy medicine professionals have been delivering quality healthcare to the fleet. As the Navy has evolved, so has Navy medicine. Today, Navy medicine provides high quality, economical healthcare to nearly 700,000 active duty Navy and Marine Corps service members and to 2.6 million active duty, retired, and family members. This healthcare is provided for about half the national per capita average cost for healthcare delivery. At the same time, Navy medicine supports contingency, humanitarian, and joint operations throughout the world.(*1*)

To meet current operations tempo requirements, Navy medicine professionals have been and will continue to be deployed to Iraq, Afghanistan, Kuwait, the Horn of Africa, Guantanamo Bay, etc., for deployments lasting as long as 12 months. The demand for Navy medicine to support combat operations on one end of the healthcare delivery spectrum affects its ability to support peacetime and garrison related care on the opposite end of the delivery spectrum. It is not unusual for Navy physicians, nurses, corpsmen, and healthcare administrators assigned to deploying platforms to have two or more combat tours under their belts within a 4-year period. Clearly, combat operations have taken a toll on the human spirit of all who serve in Navy medicine.

For Navy medicine leaders working in hospitals, serving with the Fleet Marine Force or deployed aboard naval warships, keeping talented physicians, nurses, and corpsmen in the active duty ranks, while continuing to provide quality healthcare to all eligible beneficiaries, poses enormous challenges. In order to meet its challenges and remain on the cutting edge of medicine and leadership, Navy medicine has employed a number of traditional leadership styles to motivate its men and women and to keep its many beneficiaries healthy. Total Quality Management (TQM), Management By Objectives (MBO), Plan-Do-Check-Act (PDCA), and Six Sigma are examples of leadership and management methodologies. These methods have been employed in Navy medicine to meet the many demands and challenges characteristic of today's military healthcare environment.

Because of the current and anticipated demand on Navy medicine, however, attention needs to be focused on a different style of leadership—not a new style, but rather a leadership approach that embodies humility, selflessness, commitment, mutual respect, and, above all, service. This time-tested leadership approach is Servant Leadership.

The Evolution of Servant Leadership

The term "servant leadership" was originally coined by noted leadership guru Robert Greenleaf in his groundbreaking work, *The Servant as Leader*.(*2*) Greenleaf believed that a leader's primary responsibility to his/her followers was service and that servant leadership was appropriate in all sectors of society. Servant leaders behave ethically and listen to the needs of followers and by doing so, enable them to become more knowledgeable, responsive, and better able to perform and produce in the workplace. Servant leaders rely on empowerment rather than using power to dominate and intimidate. By empowering followers and believing that each employee, irrespective of their present station in life, has the ability to help shape and move the organization forward, the servant leader is able to effectively motivate and lead. Ultimately, the organization is better served when both servant leader and follower work together in an environment of mutual trust and respect.

The typical leader today comes in two shapes—individuals who are leaders first and individuals who are servants first.(*3*) Individuals who are leaders first use power and their position within the organization to control others. Control is usually accomplished by the issuing of orders, either verbal or written. Servant leaders, on the other hand, consciously choose to be servants first and view themselves as stewards of an organization. Servant leaders will assume a leadership only if it will serve to meet the needs of the organization and its followers.

Noted leadership expert James MacGregor Burns characterized individuals who are leaders first as "transactional leaders."(*4*) In a transactional leadership situation, there is an expectation that something will be accomplished if orders are given and

obeyed. Similarly, if orders are not obeyed or are misinterpreted, there will be a negative consequence. In certain situations, transactional leadership can be effective. However, if not kept in check, transactional leadership can lead to an unduly authoritative style of leadership and the unbridled control and manipulation of others.

The best type of leadership, according to Burns, is transformational leadership.(*4*)

In a transformational leadership situation, both leader and follower are changed for the better as a result of their relationship. Transformational leaders view their interactions with followers as opportunities for mutual growth. They listen, learn, and teach. Mentoring is a large part of what they do. This type of leader is also mentored by others. Organizations where transactional leaders exist thrive through the synergistic effects of leaders and followers working together toward mutually beneficial opportunities and goals.

Taking Cues from Top Performing Civilian Hospitals

Servant leadership is being practiced by several of America's top performing hospitals. North Mississippi Medical Center (NMMC), a 650-bed tertiary care referral center for North Mississippi Health System and a recipient of the 2006 Malcolm Baldrige National Quality Award in Healthcare, has consistently concentrated its efforts on improving leader, staff, and patient engagements. According to CEO Charles D. Stokes, NMMC leaders practice humility, patience, kindness, respectfulness, selflessness, forgiveness, honesty, results orientation, and ego directed toward team accomplishments—servant leadership.(*5*) NMMC leaders "are here to serve and not to promote their own agendas."(*6*)

Gregory G. Repetti III, CEO and President of Valley Medical Center in Vail, CO, uses 360-evaluations to develop leaders. Also known as multi source evaluations or assessments, 360-evaluations are employee evaluations that are provided by superiors, subordinates, peers, the individual him/herself, and in some cases, external customers. A 360-evaluation is an especially valuable tool for the servant leader. Being able to internalize constructive criticism given by peers and subordinates and apply recommendations for improvement into one's professional life while keeping one's pride and ego in check is a true test of humility and an indicator of servant leadership.

The transfer of wisdom and knowledge from mentor to protégée is the way Mary Krause, associate vice president of medical affairs at Rush University Medical Center in Chicago, applies the principles of servant leadership in the hospital setting. Krause believes that mentoring "promotes collaboration, trust, and insight."(*7*) The mentoring relationship allows the mentor to understand his/her own weaknesses, emotions, and goals, and the degree of their influence on others. During the course of the mentoring relationship, communication skills are improved and the ethical use of power and empowerment become better understood."(*7*) Mentoring is not new to Navy medicine. There are mentoring programs currently in effect at several naval hospitals and shore commands. The question that one must ask, however, is, "Are our mentoring programs producing servant leaders?"

Servant Leadership Puts the Patient and the Organization First—Always

Being a servant leader does not mean putting oneself subordinate in function or capacity to a patient, but rather putting the needs of the patient and the organization (to include all who serve in the organization) first. Summa Health System, an organized delivery system located in northeast Ohio, and its health plan, SummaCare Inc., practices a philosophy of servant leadership and the "moment of truth," which is the first 15 seconds a healthcare professional comes in contact with a patient in need.(*8*) Summa empowers its staff to do whatever is necessary to satisfy a patient. Each staff member is made to believe that they represent Summa.

The benefits of servant leadership to both patient and the organization are clear. Servant leadership leads to improved relationships across the healthcare delivery spectrum (patients, peer groups, subordinates/supervisors, and external customers). Today's healthcare consumer is well informed and has a strong desire to participate in decisions affecting their healthcare. Patients are looking for transparency within healthcare. Words like "caring" and "compassion" are not mere clever marketing terms coined by advertising executives; these words form the ethos of SummaCare.

Service is Fundamental to Navy Medicine

Servant leadership will not mean an enormous paradigm shift for Navy medicine professionals. Navy medicine has always been rooted in service. Physicians take the Hippocratic Oath and swear to use their skills and knowledge for the benefit of patients.(*9*) Upon completion of their studies, nurses take the Nightingale Pledge and promise to devote themselves to those committed to their care.(*10*) All hospital corpsmen take the Hospital Corpsman's Pledge and dedicate their "heart, mind, and strength" to the care of the sick and injured.(*11*) For healthcare administrators who are affiliates of the American College of Healthcare Executives (ACHE), the ACHE Code of Ethics requires its members to "maintain or enhance the overall quality of life, dignity, and well-being of every individual needing healthcare service."(*12*) There are an abundance of individuals practicing servant leadership throughout the Navy. Though they may not refer to themselves as servant leaders, these individuals can be found in virtually all naval hospitals, ships, and shore commands.

Strategies on Becoming a Servant Leader—Become a Student—Again

For most, learning how to become a servant leader will involve becoming a student again. Not in the formal sense (i.e., enrolling in a degree program) necessarily, but by the undertaking of a rigorous course of study. Commercial book sellers stock an ample inventory of books on the subject of servant leadership. Information on online courses and in-residence seminars on servant leadership can easily be retrieved by entering "servant leadership courses" into an internet search query. Leadership expert Ken Blanchard contends that in order to become a servant leader, one must have a "teachable spirit."(*13*)

Ask for a periodic 360-degree assessment.

Though not a formal part of the Navy's fitness and evaluation report process, 360-degree assessments provide the servant leader with a much more complete and accurate assessment of where his/her strengths and weaknesses lie. Sample 360 assessments are available on the web and can be crafted to fit almost any work environment. Blanchard urges that the aspiring servant leader should not let pride or fear prevent a 360-evaluation from happening.(*13*) Instead, replace pride and fear with humility. "Humility is realizing and emphasizing the importance of others. It is not putting yourself down; it is lifting others up."(*13*)

Become a Performance Coach.

The third step in becoming a servant leader is to adjust one's leadership style to that of a performance coach. (*13*) Performance coaching includes performance planning, day-to-day coaching, and performance evaluation. Performance planning involves helping others by providing direction and establishing achievable goals and objectives. Day-to-day coaching enables others to achieve their goals by observing, offering praise for positive results, and constructive guidance when needed. Finally, performance evaluations should be conducted periodically and on schedule, using a 360-degree evaluation.

Develop your personal Servant Leadership mission statement.

The fourth and perhaps most important step in becoming a servant leader embodies the acknowledgment of past leadership mistakes, asking for forgiveness and making a commitment to think and behave like a servant leader from this point forward. All these elements are considered in the development of one's personal Servant Leadership statement. The following is an excerpt of a personal Servant Leadership mission statement offered by Blanchard:

"I now recognize that leadership is not all about me. It's about you, our mission, and the people we serve. Going forward, I want to serve rather than be served."(*13*)

The decision to offer one's personal Servant Leadership statement publicly or perhaps privately in the safety of one's mind whenever leadership decisions need to be made rests solely with the individual. The personal statement becomes the Servant Leader's creed.

The future of Navy medicine is dependent upon dedicated men and women who possess keen leadership acumen and an extensive and diverse knowledge of healthcare delivery systems, whether in combat operations or during peacetime garrison care. A servant leadership approach to decision-making and problem solving will enable leaders at every level to keep priorities in order while maintaining the health of all Navy medicine beneficiaries. Navy medicine, as an organization, is ready for Servant Leadership.

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BUILDING A SEA-BASED MEDICAL SUPPORT SYSTEM

PART VII: The Impact of Differing Service Perspectives on Expeditionary Operations

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As the armed forces assume a new joint expeditionary posture designed to afford global freedom of action, the entire U.S. military is restructuring its forces and operating patterns to better support both rotational forward deployments and surge operations from the U.S. and its territories. The Navy and Marine Corps have been studying new types of distributed forward deployments, most notably the sea-basing concept, which is designed to provide combatant commanders with freedom of action in theaters with little or no basing infrastructure, while concomitantly organizing forces to conduct rapid surge operations. The Air Force has organized its forces into 10 Air and Space Expeditionary Forces, with 2 on call for rotational deployments and the balance ready for surge operations. Likewise, the Army is adopting a new modular force structure of 70 brigade combat teams, designed to indefinitely sustain the forward or rotational deployments of approximately 20 combat brigades. Further, all services anticipate that military strategic mobility and logistics forces will develop the capabilities to underpin the emerging U.S. expeditionary posture.

The Evolution of "Sea-basing"

Amphibious operations of the past were focused upon assaults over the shore and into seaports to establish footholds or lodgments ashore, permitting the build-up of sufficient combat power to conduct operations against inland objectives. In this context, forcible entry forces were placed into battle to capture and render useful any in-theater seaports and airports of debarkation. Subsequently, the Cold War prompted the U.S. to adopt a more global defense posture which emphasized the forward basing of combat forces within theaters where armed conflict was most likely to occur. Since then, emerging conditions of uncertain and potentially contested access around the world have made the assumption of readily available and secure land bases open to serious question. Given the fact that the sea has now been deemed to be the most reliable and flexible environment from which joint forces could operate during the opening phases of power-projection operations, the U.S. began shifting away from a garrison posture toward one utilizing a combination of forward-deployed patrolling expeditionary combat forces, supplemented by rapidly deployable assets from bases located on sovereign American territory. Conceptually, forward-deployed naval forces conducting global patrols, when directed, could coalesce in a region to form bases at sea. These bases would substitute for land bases (a strategic concept long dormant since the end of World War II when various forms of sea-basing were extensively utilized by both the Army and the Navy).

A primary goal of the "base at sea" concept is to improve and augment "access insensitive" capabilities, implying forces that can be operated with little or no reliance on bases or other logistics infrastructure on the ground in the immediate area, even if confronted by a determined adversary. By utilizing the combination of forward deployed overseas presence, enhanced long-range strike, reach-back, surge and prepositioned capabilities, the strategic, operational, and tactical advantages of sea-basing would consequently reduce the forward "footprint" of a joint force. Stated otherwise, in addition to the traditional strategic air and sealift forces that supported the reinforcement of forward garrisons in the Cold War, the U.S. now seeks the additional capability to operate from mobile sea bases in order to seize and defend access when needed, to reinforce threatened portions of an extended defensive perimeter, or serve as the initial bridge to geographic areas not covered by an existing exterior basing network. Anticipated operations from futuristic sea-bases would then focus upon direct assault of inland objectives without operational pause by concurrently transporting, employing, and then sustaining ground forces by selective logistical replenishment from the ships comprising the base.

While Navy proponents tend to advocate the use of naval forces to completely replace land bases, others advocate a view of sea-basing in terms of an overall "joint" maritime strategy in which the fleet and Army are one weapon, with coordinated action to realize the full power of both. The latter broader joint maritime strategy, when applied to sea-basing, envisions the sea as a transient base of operations to overcome a temporary lack

of land bases. Using the sea as a base defines an area or facility from which a joint military force begins its offensive operations, to which it may fall back in case of reverse, and in which supply facilities are organized, albeit with the ability for selected offload of logistics to expeditionary forces.

Future Expeditionary Maneuver: A Controversial Perspective

The existing Maritime Transport Fleet, a legacy of the Cold War, is composed of ships comprising the Maritime Prepositioned Force (MPF), the Combat Logistics Force (CLF), the Logistics Prepositioning Force (LPF), the Surge Sealift Force (SSF), as well as the Ready Reserve Force. These are components of an "access sensitive" force constructed for performing within unimpeded and non-threatening access scenarios. Most ships assigned to these prepositioning sand surge sealift fleets require deepwater ports or anchorages to discharge their cargoes in forward theaters. They are optimized for pier-side unloading, utilizing their roll-on/roll-off ramps. In addition, the personnel who would operate the equipment carried by the Marines' MPF, as well as the Army's Combat Prepositioning Force (CPF) and the SSF, must be flown to a nearby airfield to "marry up" with the equipment and prepare for combat. Once personnel have arrived to implement this process, the consecutive implementation of reception, staging, onward movement, and integration can take a week or longer, implying that the forces associated with the ships are not ready to fight when delivered to a distant theater.

By contrast, a force designed for "uncertain access," a more likely requirement in a future world characterized by the ubiquitous presence of anti-access and area denial technologies, requires deployment and employment as one seamless step, ensuring that expeditionary combat units are both transported and directly inserted in "ready to fight" condition. The units have been charged by DOD leadership with the obligation of conducting long range operational maneuver over and from the sea, transitioning from deployment to direct combat operations with little pause. To accomplish these tasks, the services have been tasked with developing innovative operational concepts such as sea-basing, as well as pursuing enabling technologies for transformational logistics.

Regardless of whether the function of sea-based logistics is assigned to the Navy/Marine Corps' Maritime Positioning Force of the future (MPF(F)), the Army's CLF, or the multi-agency LPFs, there is an obvious need for a joint fleet of cargo ships optimized for the support of joint forces operating ashore, sized to support units conducting joint forcible entry operations, and capable of selective offload. They would be capable of sustaining the joint forces ashore until a theater logistics infrastructure can be established. The vessels would also support operations ashore in cases where the establishment of a large logistics footprint would not be prudent, or during humanitarian and disaster relief undertakings when the ashore infrastructure has been destroyed.

The Quadrennial Defense Review of 2006 and the Genesis of the Sea-Base

Since contemporary large scale Navy amphibious task forces based in the U.S. could not be formed and surge moved to a distant theater in much less than 30 days, a desire to conduct forcible entry operations more rapidly has evolved. In this context, traditional means of amphibious forcible entry have been adjudged by leadership as ill-suited for these emerging roles. Indeed, in the context of the 2006 Quadrennial Defense Review (QDR), senior defense officials posited the view that notional sea-bases of the future, composed of (MPF(F)) vessels, should be the mechanism for advancing the capability of sea-basing in support of a wide spectrum of joint force operations. They would be the most effective means for achieving both the new timeline criteria for forcible entry operations and their sustainment. As the QDR stated, "To achieve the future joint maritime force characteristics and build on progress to date, the Department will: Procure the first eight ships of the MPF(F) to improve the Department's ability to operate in restricted access environments."

Concurrently, in order to accomplish the proposed expeditionary tasks, an institutional Navy bias toward utilization of predominantly aerial maneuver over traditional surface maneuver has evolved. Consequently, amidst the planned replacements for five "big deck" amphibious assault ships, the LHA(R)s, the well decks have been eliminated in favor of increased aviation capacity. These futuristic concepts have reflected a gradual de-emphasis within Navy ship building plans for amphibious assault ships in general, and surface assault capabilities in particular.

Ironically, in the context of the 2006 QDR the sea base itself and its component vessels from the MPF(F), many of which have hulls constructed to commercial standards only, and are manned by civilian mariners, would become the leading edge of Brigade size assault/follow-on type forcible entry operations, in place of traditional amphibious landing ships. Within the MPF of the future, the proposed ships are projected to be multi-mission enabled vessels, capable not only of afloat prepositioning, but also directly involved in conducting sea-based operations in support of amphibious assault, as well as routine operations in support of lesser contingencies. As such, the MPF(F) concept of operations differs sharply from that existent for the legacy MPF maritime prepositioning ships, which serve primarily in a logistical supporting role.

Since ballistic and cruise missiles may make forward land bases vulnerable to preemptive attack, the various services have had to contemplate access insensitive forcible entry and

maneuver options, as well as programs that compensate for the initial lack of shore-based facilities. Sea-based logistical re-supply of joint forces therefore remains a key concern of all services and combat support agencies. Minimizing the supply footprint ashore by keeping supplies at sea and delivering them to units operating ashore, a process known as "selective off-load" of equipment and supplies, is viewed as a desirable capability for all future sealift ships. This requires a fleet of selective offload cargo ships to logistically support the entire early entry force (or by the differing proposals of the Army and Defense Logistics Agency: until a land-based distribution system is established, with sea-based logistics ships subsequently augmenting land-based distribution centers.)

Recognizing that the new LHA ships will have no well decks, the MPF(F) squadron concept required introduction of a new "mobile logistics platform" to mate at sea with the larger Large Medium Speed Roll On/Roll Off (LMSR) transports (making a huge, slow moving target). Its function would be: to receive equipment stored onboard the LMSRs slowly via ramps and cranes; to combat load the equipment onto the LCACs carried by the Mobile Landing Platforms (MLPs); and then to deliver the LCACs to their launch points. Unfortunately, Navy funding requests to Congress for construction of MLPs are not to be found, and only a "test feasibility run" of two substitute platforms has occurred. (Photo left.)

Experimental Mobile Landing Platform and Cargo Ship

During this era of guided missile warfare, the notion that commercially designed Military Sealift Command crewed ships of an "operationalized" MPF(F) fleet would be part of the assault echelon of a joint forcible entry operation in a contested littoral, has been viewed as potentially dangerous. Realistically, the MPF(F)s role to embark and then deploy Marines ashore while sustaining expeditionary warfare operations potentially exposes these ships and embarked Marines to hostile fire. Indeed, strategists have cautiously viewed the proposed precarious practice of lashing two large offloading cargo ships together when operating under the threat of guided missile or nuclear attack, and expressed concerns that the conjoined ships would create a giant, immobile target for an adversary. In addition, before landing his force from an MPF(F) squadron, a Marine Expeditionary Brigade commander would face the prospect of conducting ship-to-ship transfers of both men and equipment among ships during times of decreased visibility, possibly during sea states 3 or 4, thereby injecting further friction into one of the most complicated military operations imaginable. These operations would include the transfer of a Brigade's worth of equipment between ships, at night, in the rain, in high sea states with tired Marines using night vision goggles, and without having the benefit of a rehearsal.

Unfortunately, the 2006 QDR reflects no great concern over either the possible future deployment of anti-access/area-denial networks by adversaries, or the Joint Forces' ability to penetrate them. Unlike traditional amphibious forcible entry access insensitive fleet ships, the MPF(F) ships will carry no defensive armament, will be built to less stringent damage control survivability standards, and will not be able to venture into a littoral contaminated by radiological, biological, or chemical fallout. Since the Navy plans to protect the MPF(F) ships through employment of a naval "Sea Shield," it does not plan to outfit MPF(F) ships themselves with self defense features. Consequently, the Navy's proposal to eliminate the self defense features for the LHA® has raised concerns regarding the survivability of these MPF(F) ships. In addition, ship-wide damage control on the MPF(F) ships will remain the responsibility of the embarked Marines themselves, since the small crew size of the MSC-manned MPF(F) ships will be incapable of performing the entire task on their own.

The Ultimate Differing Perspectives among the Services: The Army's Philosophic Differences

Army planners have long been cognizant of the lessons of World War II when many Army units, like Marine units, had been carried to combat as intact expeditionary units aboard amphibious ships. It is not surprising, therefore, that Army planners have conceived of a new type of austere access Shallow Draft High Speed Ship (SDHSS) as a key means to enable future Army operational maneuver from strategic distances. The SDHSS does not require a fixed port because it can discharge its combat power wherever there is a 10-foot draft and an acceptable beach gradient or discharge site. Unfortunately, unilateral development of this vehicle typifies the problem of a service specific approach to operational maneuver from the sea, which differs from the exclusive vertical envelopment architecture of the MPF(F) proposed by the Navy.

The Army would also like to expand its CPF of the future to include an "afloat forward staging base" large enough to embark an air assault brigade combat team followed by moves to capture seaports or safe shore lodgments for heavier follow-on forces. Notionally, the base would shift operations ashore as soon as possible and allow the base to operate as a selective offload logistics sustainment facility. Similarly, the Army is pursuing a Supply Support Activity Afloat (SSAA), designed to provide selective offload of cargo to early arriving Army units until the Joint theater logistics infrastructure is established ashore. In other words, the Army presumes that any major joint power-projection operations will ultimately require the establishment of permanent bases and logistics infrastructure ashore.

The "QDR" Ignored

The QDR of February 2006 advised that all the organizations, processes, and practices within the DOD be given a high degree of agility, flexibility, responsiveness, and ultimately effectiveness in supporting the joint war fighter and future national defense goals. In such an expeditionary posture, the value of maritime forces in general, and sea-basing in particular, gained prominence. Nevertheless, within the latest 2007 unified maritime statement jointly issued by the Navy, Marine Corps, and Coast Guard, "A Cooperative Strategy For 21st Century Seapower," the commission of any substantive discussion of "sea-basing" is evident. Its absence suggests that this central theme may no longer have operational relevance in the domain of the sea services. By omitting any discussion of the general strategic, operational, and tactical advantages of sea-basing, the authors of the cooperative strategy ignored an important opportunity to further define the Sea Services' strategic concept and its joint implications. This omission is inconsistent with the 2006 QDR, which stressed the need for innovative basing concepts to maximize U.S. global freedom of action.

To some observers, this lack of discussion suggests that the sea services now view sea-basing in simply programmatic terms (e.g., what platforms to buy) rather than as a strong foundation for any maritime strategic concept of operations. Unfortunately, this important omission also reflects a lack of any acknowledgment of how other components of the joint force, namely Army and Air Force, also contribute to the maritime strategic concept, and how their contributions can allow the sea services to re-allocate their own resources for other purposes. References to the joint force are few and far between, and are made almost exclusively in terms of what maritime forces bring to the joint force, not vice versa. Similarly, never mentioned is the dependency of maritime forces upon space forces, on Air Force tankers and surveillance and reconnaissance assets, or on Air Force long-range bombers or fighter aircraft. Never discussed, as well, is the need to develop a new collaborative doctrine with the Air Force for dealing with rising maritime anti-access and area-denial threats.(*1*)

The Common Denominator for Joint Medical Support

Within a futuristic joint theater of operations, the requirements for establishment of adaptive medical support for networked and distributed expeditionary operations mandate both full understanding of the programmatic "concept of operations" (CONOPS) of a joint sea-base, as well as a familiarity with the new and differing trends in war fighting being proposed across service lines by the combat arms. The promulgation of a generic CONOPS for the joint sea base concept would provide an overview of the vision, purpose, and planning required for developing and implementing specific military initiatives. It would further provide the information and high level guidance needed to enable managers and decision makers, including those responsible for healthcare support services, to perform their duties consistent with and in support of the action being implemented.

When considering the formulation of any medical support objectives in a sea-based setting, premature development of future medical systems to meet individual service needs, rather than joint requirements, may result in initiatives that duplicate each other and may be neither interoperable nor compatible. Clearly lacking is a formal senior level CONOPS established by DOD leadership for the operation of the integrated joint sea base. This is also necessary for establishing common and stable standards for building a truly joint and interoperable military medical support network in the sea base setting, and for facilitating a spirit of cooperation and shared values among all the sister medical services and agencies, as well as allied foreign military services.

The 2006 QDR recommended that medical support be aligned with emerging joint force employment concepts. Unfortunately, aspirations of joint unity will not be easily attained due to the separate and unique role that each service has traditionally maintained during war. Ultimately, a resolution of existing differences in operational perspective of sea-basing is mandatory before establishment of any joint casualty care programs can be seriously undertaken.

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1. Tol Work R. "A Cooperative Strategy for the 21st Century Seapower" (Washington, DC, Center for Strategic and Budgetary Assessments) 26 March 2008.

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CAPT Ruth A. Erickson, NC, USN (Ret.), fifth Director of the Navy Nurse Corps from 1962 to 1966, died at her home in Rochester, MN, on 25 November. She was 95. Erickson graduated from Methodist-Kahler School of Nursing in Rochester, MN, in 1934 before joining the Navy Nurse Corps in July 1936. Her first assignment was Naval Hospital San Diego. From November 1938 until April 1940 she served aboard the hospital ship USS *Relief* (AH-1). In May 1940 she was assigned to Naval Hospital Pearl Harbor and was there during the Japanese attack of 7 December 1941. In later years, during an interview for the BUMED Oral History Program, she recalled that fateful Sunday morning:

"Two or three of us were sitting in the dining room Sunday morning having a late breakfast and talking over coffee. Suddenly we heard planes roaring overhead and someone said, 'The fly boys are really busy at Ford Island this morning.' We no sooner got those words out when we started to hear noises that were foreign to us.

"I leaped out of my chair and dashed to the nearest window in the corridor. Right then there was a plane flying directly over the top of our quarters, a one-story structure. The rising sun under the wing of the plane denoted the enemy. Had I known the pilot, one could almost see his features around his goggles. He was obviously saving his ammunition for the ships. Just down the row, all the ships were sitting there—the *California*, the *Arizona*, the *Oklahoma*, and others.

"My heart was racing, the telephone was ringing, the chief nurse, Gertrude Arnest, was saying, 'Girls, get into your uniforms at once. This is the real thing!'"

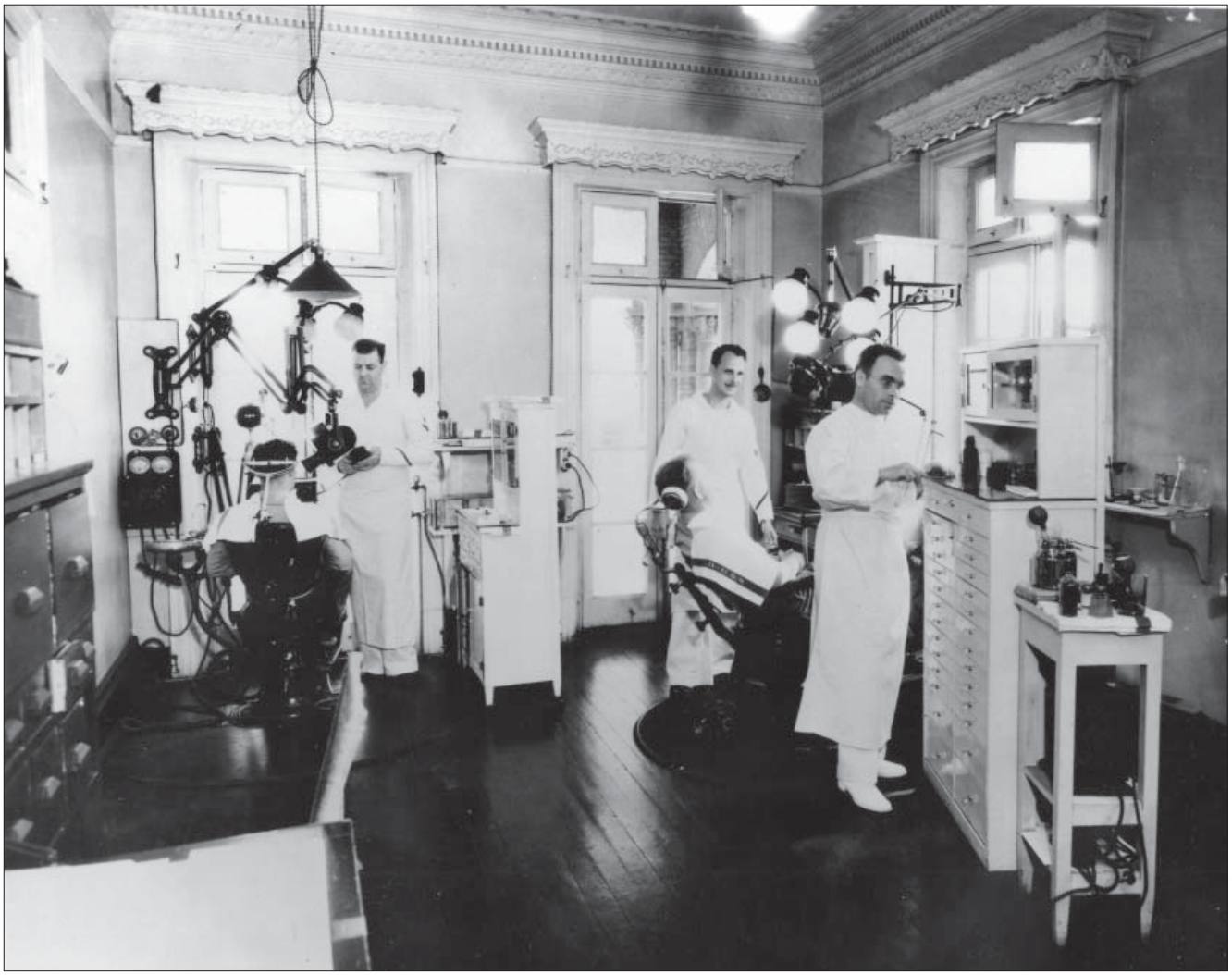
Twelve days after the attack, then ENS Erickson accompanied the first war casualties who were evacuated to CONUS aboard the liner USS *President Coolidge*. From April 1945 until March 1946 she was again assigned to a hospital ship, this time USS *Haven* (AH-12), as Chief of Nursing Service. As fate would have it, *Haven*, with LT Erickson aboard, arrived at Pearl Harbor in August 1945, just days before the Japanese announced their intention to surrender, and was there when World War II ended on 2 September. Eight days later *Haven* arrived off Nagasaki and brought aboard a group of ex-prisoners of war. While there, she went ashore and saw first-hand the terrible destruction visited upon that city by the recent nuclear attack.

"Upon my request to the medical command, we got permission for a number of us to be driven by bus to a convent. It was a large stately white building sitting on the highest terraced area overlooking the city. The ride revealed nothing but rubble and desolation. The nun in charge was astounded to see a group of white American women. We asked many questions, the main being what had they witnessed. She answered immediately, 'There was a very brilliant white light. This was the end of the world. Christ was coming.'"

Following the war, LCDR Erickson served as nursing supervisor, senior nurse, and Assistant Chief of Nursing Service in naval hospitals and dispensaries at Corona, CA; Farragut, ID; St. Albans, NY; Brooklyn, NY; and Great Lakes, IL. As Nurse Corps representative, she was assigned to the District Medical Office, 12th Naval District, San Francisco, from 1947 until 1949, and then as Senior Nurse Corps officer in the Port Office, Military Sea Transportation Service, North Pacific, Seattle, WA, until 1950, when she was assigned as Nurse Corps Personnel Officer, BUMED, Washington, DC. She served in that post until 1952. Following duty under instruction at Indiana University in 1952, where she received a bachelor's degree in nursing education, CDR Erickson served as Chief of Nursing Service at Naval Hospitals Camp Lejeune, NC; Portsmouth, VA; and NNMC, Bethesda, MD. CAPT Erickson was appointed Director, Navy Nurse Corps on 30 April 1962. As Nurse Corps Director, she promoted nursing education, the improvement of nursing administration, and increased opportunities and advancement for Navy nurses.

Her awards included the Navy Unit commendation, American Defense Service Medal with one star, American theater Medal, World War II Victory Medal, Navy Occupation Service Medal, National Defense Service Medal, and the Asiatic-Pacific Medal.

Navy Medicine 1934



BUMED Archives

Dental clinic of the Regimental Hospital, 4th Marine Division, Marine Corps Expeditionary Forces, Shanghai, China.

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